Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name
Ace American Insurance Co.

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-10-4192-01

MFDR Date Received
June 1, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pine Creek Medical Center is requesting that this claim be paid per the APC rate."

Amount in Dispute: $3,825.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Further, Requestor contends that they did not receive notice that this PPO contract would/could be used. However, that is incorrect. Requestor, via the TDI website's informal network page, had notice that Respondent and Gallagher Bassett, its third party administrator for Respondent could/would use the Aetna PPO contract. Also, the EOB indicated that the bill was paid in accordance with the Aetna contract which is also notice."

Response Submitted by: Downs & Stanford PC

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2009	Outpatient Hospital Services	$3,825.10	$3,825.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 3, 2009
   - C – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCE ABOVE

   Explanation of benefits dated March 17, 2010
   - 16 (16) – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIES USING REMITTANCE ADVICE REM
   - 45 (45) – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
   - 16 (16) – THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL
   - 45 (45) – THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

   Explanation of benefits dated May 2, 2010
   - 16 (16) – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIES USING REMITTANCE ADVICE REM
   - 45 (45) – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
   - 16 (16) – THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL
   - 45 (45) – THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL
   - BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR THE

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required.

   - The notice does not include the start date and any end date during which the insurance carrier had been given access to the contracted fee arrangement as required by §133.4(d)(2)(B).
   - No documentation was found to establish time of notification in accordance with §133.4(f).

   The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 29862, date of service October 31, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $1,898.20. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,198.64 at 2 units, with multiple-procedure discount, is $4,797.96. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.24. This ratio multiplied by the billed charge of $7,800.00 yields a cost of $1,872.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $4,797.96 divided by the sum of all APC payments is 75.00%. The sum of all packaged costs is $3,149.95. The allocated portion of packaged costs is $2,362.46. This amount added to the service cost yields a total cost of $4,234.46. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $4,797.96. This amount multiplied by 200% yields a MAR of $9,595.92.

   - Procedure code 29863, date of service October 31, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of $1,898.20. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,198.64. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line, including multiple-procedure discount, is $1,599.32. This amount multiplied by 200% yields a MAR of $3,198.64.

   - Per Medicare policy, procedure code 76000, date of service October 31, 2009, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

   - Procedure code 97001, date of service October 31, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $70.58. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division conversion factor of 53.68 yields a MAR of $105.05. The recommended payment is $105.05.

   - Procedure code 97116, date of service October 31, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $24.70. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division conversion factor of 53.68 yields a MAR of $36.76. The recommended payment is $36.76.

4. The total allowable reimbursement for the services in dispute is $12,936.37. The amount previously paid by the insurance carrier is $5,825.50. The requestor is seeking additional reimbursement in the amount of $3,825.10. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,825.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,825.10, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 8, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.